Complete Summary

GUIDELINE TITLE

Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder.

BIBLIOGRAPHIC SOURCE(S)

Steiner H, Remsing L, Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. J Am Acad Child Adolesc Psychiatry 2007 Jan;46(1):126-41. [108 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Oppositional-defiant disorder (ODD), and associated conditions, such as:

- Conduct disorder (CD)
- Disruptive behavior disorder (DBD)
- Attention-deficit/hyperactivity disorder (ADHD)

GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation

Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Family Practice
Pediatrics
Psychiatry
Psychology

INTENDED USERS

Allied Health Personnel
Physicians

GUIDELINE OBJECTIVE(S)

To make recommendations regarding diagnosis and treatment of oppositional-defiant disorder (ODD)

TARGET POPULATION

Children and adolescents ages 18 and younger with or at risk for oppositional-defiant disorder (ODD)

INTERVENTIONS AND PRACTICES CONSIDERED

1. Therapeutic alliances with the child and family for assessment and treatment
2. Consideration of cultural issues in diagnosis and treatment
3. Use of information from child and parents regarding symptoms
4. Consideration of comorbid psychiatric conditions in diagnosis and treatment
5. Use of information from multiple outside informants for evaluation and treatment
6. Use of questionnaires and rating scales for evaluation and in tracking progress
7. Development of individualized treatment plans
8. Use of parent interventions
9. Use of medications as adjuncts to treatment packages for symptomatic treatment and to treat comorbid conditions
10. Intensive and prolonged treatment when oppositional defiant disorder (ODD) is severe and persistent

MAJOR OUTCOMES CONSIDERED

- Effectiveness of evaluation and diagnosis of oppositional defiant disorder (ODD)
- Responsiveness to treatment
- Degree of oppositionality
- Persistence of ODD
- Progression of ODD to conduct disorder (CD)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A National Library of Medicine search was initially performed in 1999, covering the preceding 5 years. Using a combination of *PsycINFO* and *Melvyl* on-line systems, the following topics were reviewed: oppositional defiant disorder (290 articles), oppositional defiant disorder and adolescence (53 articles), oppositional defiant disorder and delinquency (8 articles), disruptive behavior disorder (285 articles), aggressive behavior and adolescence (255 articles), aggressive behavior and delinquency (83 articles), and treatment of delinquency (97 articles). This search was updated periodically (most recently in May 2005) to identify new articles. Some pertinent publications published before the 5-year search period were also reviewed, as were review articles addressing these issues. In determining the final list of references to be included in this document, the authors relied heavily on recent reviews and summaries of the literature to keep the list manageable.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The parameter was developed by two American Academy of Child and Adolescent Psychiatry physicians and the Work Group on Quality Issues.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets following the statement. These categories indicate the degree of importance or certainty of each recommendation.

[MS] *Minimal standards* are recommendations that are based on rigorous empirical evidence (e.g., randomized, controlled trials) and/or overwhelming clinical consensus. Minimal standards are expected to apply >95% of the time (i.e., in almost all cases).

[CG] *Clinical guidelines* are recommendations that are based on empirical evidence and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases). These practices should almost always be considered by the clinician, but there are significant exceptions to their universal application.

[OP] *Options* are practices that are acceptable, but not required. There may be insufficient empirical evidence and/or clinical consensus to support recommending these practices as minimal standards or clinical guidelines.

[NE] *Not endorsed* refers to practices that are known to be ineffective or contraindicated.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This parameter was reviewed at the member forum in October 2003 at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry (AACAP). In 2005, a consensus group reviewed and finalized the content of this practice parameter. The consensus group consisted of representatives of relevant AACAP components as well as independent experts. This practice parameter was approved by AACAP Council on June 17, 2006.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the categories of endorsement for the recommendation (MS, CG, OP, NE) are provided at the end of the "Major Recommendations" field.

Recommendation 1. Successful Assessment and Treatment of Oppositional-Defiant Disorder (ODD) Requires the Establishment of Therapeutic Alliances With the Child and Family **[MS]**.

In obtaining information for both assessment and subsequent treatment, the success of these tasks will require building a therapeutic alliance with the parents and the child separately. Building that coalition while avoiding being drawn into a power struggle frequently requires patience and perseverance. Clinicians must aim to quickly clarify their role as helpers to the patient. One caveat must be heeded in collecting collateral information (from parents and teachers): Relying extensively on collateral information may further alienate patients and prevent clinicians from engaging them appropriately, although this may vary with the age of the child. Children are usually brought in by parents and often are not in agreement with the nature (or existence) of the problems and frequently lack the motivation to resolve them. Engagement with the child is often best achieved by empathizing with the patient's anger and frustration while refraining from sanctioning oppositional/aggressive behavior. Most patients do realize that their behavior is out of line, although this capacity is age dependent. They defiantly tend to rationalize their behavior as justified by the circumstances, but they are not happy about it. This admixture of anger, defiance, insight, and unhappiness opens a unique door for alliance building.

Simultaneously, the clinician needs to constructively raise issues regarding efficacy of parenting without making the parent feel accused or judged. This is best done through compiling an exhaustive list of parental strategies currently being used to contain or deal with the child's behavior. Questions can be raised about how these strategies work and whether the parents think they have achieved the desired short and long-term outcomes. The clinician needs to convey empathy with the parent's frustration without allying unduly with them.

Recommendation 2. Cultural Issues Need to Be Actively Considered in Diagnosis and Treatment **[MS]**.

The literature does not adequately discuss the role of ethnicity on treatment and outcome. However, there is a substantial body of literature on different standards of parenting in different ethnic subgroups and the efficacy and risks of such practices. There is also a growing body of literature regarding the risks clinicians encounter when approaching cases in a culturally insensitive fashion. Of particular interest are different standards of obedience and parenting in ethnic subgroups. It is probable that such differences are not easily discussed when the treatment is offered by a person from another ethnic background. To become effective, the clinician needs to be sensitive to these areas of mismatch in patient/doctor backgrounds and should be prepared to be educated. This is particularly relevant in ODD because discipline is bound to be a core point of discussion in every case.

Recommendation 3. The Assessment of ODD Includes Information Obtained Directly From the Child As Well As From the Parents Regarding the Core Symptoms of ODD, Age at Onset, Duration of Symptoms, and Degree of Functional Impairment **[MS]**.

Typically, the child or adolescent is brought in by his or her parents for problems that are contained within the home, but with increasing severity get out of control in situations outside the home because the child or adolescent is being persistently antagonistic and unpleasant. The forms of aggression reported are more likely to be minor and verbal, as opposed to the more severe, physical forms encountered in conduct disorder (CD). The child does not necessarily see his or her behavior as a problem, or may even see it as a justified response to particular contextual circumstances. These problems are not transient and lead to interference in several domains of functioning.

Delineation of ODD from normative oppositional behavior, transient antisocial acts, and CD is of paramount importance for the clinician, but difficult. Isolated occurrences of oppositional behavior in a child or adolescent with good levels of premorbid functioning and preserved functioning in the majority of his or her current domains are more likely associated with a positive prognosis. This is especially true if it can be shown that some of his or her problems are the result of peer-related conflicts or a recent significant stressor. The clinician always needs to explore carefully the possibility that the child's oppositionality is triggered or even caused by incidences of physical abuse, sexual abuse, or neglect in the family or in the child's extended social orbit, and thus are reactive and contextually driven.

Oppositional-defiant behaviors may be present in some settings and not in others. Commonly, a child may be difficult with parents but compliant in school and with other adult figures. The clinician must also consider that children sometimes become oppositional in response to excessive and unrealistic parental demands or that these demands may reinforce the child's maladaptive response.

A portion of the assessment of the child with ODD should take the form of a functional analysis of the child's behavior, including identification of the antecedents and consequences of the child's behavior and parent and others' behavior that may reinforce the child's problem behaviors. Parents may unwittingly reinforce a child's coercive or oppositional behavior. Parents who complete a task originally assigned to a child have just reinforced that child's negative behavior. Alternatively, reinforcement of problem behavior can also occur when a parent repeatedly desists from a demand and an uncomfortable confrontation as the child escalates in his or her oppositionality and coercion.

Many of the problematic behaviors of ODD will not necessarily manifest themselves directly with the examiner in an initial contact (except in the most severe cases), but would be apparent in interactions with the primary caregiver(s). It is also important to document the unrelenting nature of the problem. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (May 2000 text revision) (DSM-IV-TR) specifies a minimum duration of 6 months. Exasperated parents may request intervention long before that, and early intervention using the same modalities is reasonable in these cases. An associated issue of great importance is the assessment of children's access to weapons and supervision of such. In all cases, multiple settings and multiple pathogenic processes need to be considered for an exhaustive assessment, and the interaction of these variables needs to be described.

A special issue relevant to the assessment of this domain is the child's involvement in bullying as either a victim and/or as a perpetrator. Such interactions may serve as an additional indicator that the child's functioning is impaired and that he or she is at risk for aggression and even violence.

Recommendation 4. Clinicians Should Carefully Consider Significant Comorbid Psychiatric Conditions When Diagnosing and Treating ODD **[MS]**.

The assessment of comorbidity in ODD is an important part of the evaluation because the condition is usually highly comorbid. As a first step, the clinician needs to delineate whether this is truly ODD or a simple adjustment reaction. The second step is to determine whether this is still ODD or already has progressed to CD.

Comorbid conditions require treatment along with treatment of the ODD behaviors. If these comorbid conditions respond to treatment, then oppositionality may lessen or even disappear. This expectation may be particularly relevant if the comorbid condition precedes the onset of oppositionality.

The clinician should be aware of the common increase of disruptive behavior with chronic pediatric illness. Clinicians should establish whether the child is receiving ongoing pediatric care. It would be prudent to have the most recent pediatric examination available for review upon initial assessment. The clinician also should inquire about the child's age-appropriate compliance with the pediatric treatment.

Recommendation 5. Clinicians May Find It Helpful to Include Information Obtained Independently From Multiple Outside Informants **[CG]**.

Clinicians should consider information from multiple informants, such as daycare providers, teachers, and other school professionals. External observations help in determining that despite variation in the social environment, the child continues to manifest oppositional behavior. This information will help determine how many domains of functioning are affected, and confirm the diagnosis. Although such information is useful and important, the clinician should be aware that there is generally a relatively low rate of agreement between multiple informants, raising the issue of which report should be considered more clinically meaningful. Teachers and parents tend to agree more with each other in terms of externalizing behaviors than with the child. However, children's self-reported problem behaviors are better predictors of stability after 1 year, especially when covert acts are involved. This requires that the clinician be prepared to make an educated judgment when conflicting information arises, one of the hazards of this practice.

Parents and youths may manifestly disagree when describing the nature and origin of the problem. Such disagreements can be difficult to reconcile without the input of neutral informants outside the family, such as teachers, especially in cases involving child abuse. The need to complete a database must be counterbalanced with the consequences to the treatment alliance.

Recommendation 6. The Use of Specific Questionnaires and Rating Scales May Be Useful in Evaluating Children for ODD and in Tracking Progress **[OP]**.

A wide range of instruments and interviews have been developed that measure oppositional behavior and other forms of aggression in childhood and adolescence in many different settings. Table 2 in the original guideline document summarizes some instruments that may be applicable to clinical practice. A variety of structured and semistructured interviews are supported by favorable psychometric properties. Most of these instruments include a special module for the assessment of disruptive behavior disorders (DBD).

Scales can be useful in clinical practice not only to help establish the diagnosis but also to track progress and response to intervention(s). Most of these instruments use continuous measures of diverse constructs, standardizing disruptive or aggressive behavior for different ages. This can lead to scores that can be compared to age-appropriate ranges, aiding in the delineation of normative and non-normative behaviors.

Recommendation 7. The Clinician Should Develop an Individualized Treatment Plan Based on the Specific Clinical Situation **[MS]**.

As with the treatment of all psychiatric disorders, the clinician should develop a treatment plan in accordance with a biopsychosocial formulation of the case. Given the current understanding of ODD, interventions should target domains that are assessed as dysfunctional. Because of the frequent presence of comorbidity and multiple dysfunctional domains, multimodal treatment is often indicated. Different modalities may be more important for individual cases, depending on the age of the child; the severity of the presenting problems; and the goals, resources, and circumstances of the parents. Treatment must be delivered for an adequate duration (usually several months or longer) and may require multiple episodes either continuously or as periodic booster sessions, reinforcing previous skills or improvements. Many authorities suggest that the treatment of ODD, not unlike the treatment of CD, be multitarget, multimodal, and extensive, combining individual psychotherapy, family psychotherapy, pharmacotherapy, and ecological interventions (including placement and school-based interventions), especially when severe and persistent.

The two types of evidence-based treatments for youth with ODD are individual approaches in the form of problem-solving skills training and family interventions in the form of parent management training. Individual approaches should be specific to problems encountered, behaviorally based, and as much as is possible oriented to the development of problem solving skills. Family interventions (see recommendation 8) are among the best-studied treatments in this context. They usually encompass training in effective disciplining and age-appropriate supervision. Ecological interventions offer the opportunity for early intervention at different levels of intensity (as in school-based programs) and provide safety when this is an issue for a particular patient (as in hospitalization and residential placement).

Different ages may call for different admixtures of these treatments. In preschool, emphasis should be placed on parental education and training. In school-age, school-based interventions, family-based treatment, and occasionally individual approaches are indicated. In adolescence, individual approaches are more often used along with family interventions. Throughout all ages, psychopharmacological interventions can be useful adjuncts.

Recommendation 8. The Clinician Should Consider Parent Intervention Based on One of the Empirically Tested Interventions **[MS]**.

Parent management training in the use of contingency management methods to help them better handle disruptive behavior is one of the most substantiated treatment approaches in child mental health. The principles of these approaches can be summarized as follows:

1. Reduce positive reinforcement of disruptive behavior.
2. Increase reinforcement of prosocial and compliant behavior. Positive reinforcement varies widely, but parental attention is predominant. Punishment usually consists of a form of time out, loss of tokens, and/or loss of privileges.
3. Apply consequences and/or punishment for disruptive behavior.
4. Make parental response predictable, contingent, and immediate.

These interventions are effective in community and clinical samples. They target one of the most studied causal processes by which children become oppositional—their coercive response to parental demands, and ways in which parents unwittingly reinforce the child's noncompliance. Almost all of the best known and evidence-based parent management training programs are variations of Hanf's two-stage behavioral treatment model and are listed in Table 2 of the original guideline document. Defined as model programs by Substance Abuse and Mental Health Services Administration, these programs are available for dissemination and offer technical assistance and training by their developers. The programs have multimedia formats on videotape or DVD and are manual based. Other family therapies include models designed for prevention or intervention with youths with CD and/or substance use disorders. These therapies include functional family therapy and multimodal systemic therapy.

The issues associated with family or parental approaches are as follows: the use of mild forms of spanking, the high treatment dropout rates with these families and their children (sometimes up to 50%), and the existence of parental psychopathology, which impedes participation and progress. Adverse side effects may be the misuse of the techniques to control children, especially in abusive homes, and the possibility of these intervention techniques resulting in increased or more severe confrontations between child and marginally controlled parents.

Recommendation 9. Medications May Be Helpful as Adjuncts to Treatment Packages, For Symptomatic Treatment and to Treat Comorbid Conditions **[CG]**.

At this point, medications for youth with ODD are mostly considered to be adjunctive, palliative, and noncurative. Medication should not be the sole intervention in ODD. Medication trials are most effective after a strong treatment alliance has been established. Prescribing medications only at the parent's request without enlisting the child's support or assent is unlikely to be successful, especially if an adolescent is involved. After starting medications, adherence, compliance, and possible diversion need to be monitored carefully. Nonresponsiveness to a specific compound should lead to a trial of another class of medication rather than the rapid addition of other medications. Polypharmacy may further cloud these already complicated cases.

Pharmacotherapeutic interventions for ODD are not well studied, but several agents have received support in open-label and double-blind placebo-controlled studies of disruptive behavior (CD or ODD) in the context of other principal diagnoses. Medications, such as stimulants and atomoxetine, used to treat ODD in the context of other principal diagnoses such as ADHD, may result in improvement of the oppositional behavior as well.

Results from controlled clinical trials when CD was the principal diagnosis for inclusion show promise for mood stabilizers such as divalproex sodium and lithium carbonate, antipsychotics, and stimulants. The targets of these trials are invariably aggressive behavior. Regardless of diagnosis, atypical antipsychotics seem to be the most commonly prescribed medications for the treatment of acute and chronic maladaptive aggression. It is recommended that medications be started only after an appropriate baseline of symptoms or behaviors has been obtained because starting before that point may lead the clinician to attribute effects to drugs that were actually caused by a stabilizing environment.

Because aggressive and oppositional behavior complicates a wide range of other diagnoses in this age range, it is recommended that if comorbid conditions are present, then medication should be targeted to those specific syndromes as much as possible. Several open and double-blind placebo controlled studies show that typical and atypical antipsychotics are helpful in treating aggression after appropriate psychosocial interventions have been applied in the context of mental retardation and pervasive developmental disorders. If the first medication is not effective, then a trial of another atypical or a switch to a mood stabilizer is recommended.

Recommendation 10. Intensive and Prolonged Treatment May Be Required If ODD Is Unusually Severe and Persistent **[CG]**.

Although typically more severe, persistent cases of ODD eventually meet diagnostic criteria for CD, ODD cases that are subthreshold for CD exist. Lack of progress is one consideration driving placement considerations because placement is usually considered a measure of last resort. As in the treatment of other disorders, issues of the safety of the patient and those around him or her need to be considered. Self-injurious behavior may be thinly disguised as extreme recklessness, and poor impulse control along with extreme irritability may rapidly progress into situations in which harm to self or others becomes a major issue. Predatory or planned aggressive behavior before school age is rare, but begins to emerge in the school years, dominates during adolescence, and generally is associated with poor outcomes.

A concern in severe cases is determining the appropriate level of care. Treatment ought to be carried out in the least restrictive setting, one that guarantees safety and allows for a regular delivery of interventions. Increased levels of care may need to be considered and restricted to the shortest possible intervals to guarantee safety and progress. Day treatment, residential, and hospitalization facilities may need to be considered if the family is unable or unwilling to collaborate with the treatment of a more severe case of ODD. Hospitalizations are needed for crisis management only. Out-of-home community-based alternatives to residential placement include therapeutic foster care and respite care.

Placement in residential facilities also has some associated risks, such as separation from the family and occurrences of institutional victimization. Risks and benefits of placement need to be carefully weighed because treatment gains in structured settings do not necessarily generalize to the community and family. Rapid return to community and family should be the basic goal while treatment is provided in a safe and efficient manner.

Intensive in-home therapies such as multisystemic therapy, wraparound services, and family preservation models such as Homebuilders, which are often sponsored by child welfare agencies, are preferable alternatives to residential placement.

Recommendation 11. Certain Interventions Are Not Effective **[NE]**.

Experts agree that any dramatic, one-time, time-limited, or short-term intervention is usually not going to be successful. Inoculation approaches continue to resurface in a variety of forms (e.g., boot camps, shock incarceration). These approaches are at best ineffective and at worst injurious, especially when used in isolation from evidence-based approaches. Exposure of children and adolescents to frightening scenarios or situations, which are meant to induce them to desist from aggressive behaviors while not offering any other behavioral alternatives, only serve to worsen such symptomatic behaviors through heightening a fear-aggression reaction or modeling of deviance.

Definitions:

Rating Scheme for the Strength of the Recommendations

Each recommendation is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets following the statement. These categories indicate the degree of importance or certainty of each recommendation.

[MS] *Minimal standards* are recommendations that are based on rigorous empirical evidence (e.g., randomized, controlled trials) and/or overwhelming clinical consensus. Minimal standards are expected to apply >95% of the time (i.e., in almost all cases).

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[NE] Not endorsed refers to practices that are known to be ineffective or contraindicated.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and treatment of oppositional-defiant disorder (ODD)

POTENTIAL HARMS

Adverse side effects to parent interventions may be the misuse of the techniques to control children, especially in abusive homes, and the possibility of these intervention techniques resulting in increased or more severe confrontations between child and marginally controlled parents.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- A note of caution must be given considering there are few controlled clinical trials specific to oppositional defiant disorder (ODD) comparing treatment modalities such as parent training versus individual approaches. Consequently, except for parent training and some pharmacological approaches, current recommendations regarding the use of modalities such as individual therapy are based on clinical wisdom and consensus rather than extensive empirical evidence. There is some indication, from a retrospective analysis of a large case series, that dynamically oriented approaches may be useful as well.
- Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision-making. These parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe effective and generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These parameters are not intended to define the standard of care; nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 Jan

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry

GUIDELINE COMMITTEE

Work Group on Quality Issues

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

This parameter was developed by: Hans Steiner, M.D.; Lisa Remsing, M.D., principal authors

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Dr. Steiner is a consultant/advisor for Abbott Pharmaceuticals and Janssen. He serves on the speakers' bureau of Eli Lilly. He has unrestricted educational grants from: Abbott, Eli Lilly, Pfizer, Ortho-McNeil, and Shire, and has received research grants from Janssen and Abbott. Dr. Remsing has no financial relationships to disclose.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format from the American Academy of Adolescent and Child Psychiatry (AACAP) Web site.

A CD-ROM containing all parameters is available for a fee. See the AACAP Publication Store for more information.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on March 8, 2007. The information was verified by the guideline developer on April 3, 2007.

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